DCH/LNR-501 (03/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, Michigan 48909
(517) 335-0918

REGISTERED NURSE AND PRACTICAL NURSE LICENSURE BY ENDORSEMENT INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Nursing. Questions regarding your application can be directed to the Michigan Board of Nursing at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INFORMATION

1. The Michigan Board of Nursing may issue a license by endorsement to an applicant who is currently licensed in another state if that state's licensure requirements are substantially equivalent to those required in Michigan.

2. Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application. You must provide a complete listing of **all states** (excluding temporary licenses) in which you have **ever** held a nursing license.

3. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

4. You are required by law to notify this office within 30 days if:

   a. **YOU CHANGE YOUR NAME** - Send a letter advising us of the name change. Please be sure to include your license number and the name under which you are currently licensed as well as your new name.

   b. **YOU CHANGE YOUR ADDRESS** - Send correct address information including street number, street name, apartment number, P.O. Box or R.D. number, city, state and ZIP Code. Be sure to include your license number in the correspondence.

   To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax the form to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

5. It is a violation of the Michigan Public Health Code, to practice nursing in Michigan without a license issued by Michigan.

6. In order to practice as a Nurse Specialist in Michigan, you must apply for and obtain a separate Nurse Specialty license. You can obtain the Nurse Specialty application by calling 517-335-0918 or on-line at www.michigan.gov/healthlicense.

7. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Nursing in writing to request a refund.

REGISTERED NURSE LICENSURE BY ENDORSEMENT INSTRUCTIONS

1. Complete the application for licensure in its entirety and submit it with the required fee. Applications submitted without the licensing fee will be returned.

2. You must complete **PART I** of the enclosed Registered Nurse Endorsement form and mail it to the state in which you were originally licensed by examination for completion of **PART II** by that state. **Contact your original state of licensure for information regarding fees charged for this service.**

3. In addition to the Endorsement form from your original state of licensure, a Verification of Licensure form must be forwarded to this office **from** EACH additional state in which you hold or have ever held a nursing license. The Verification of Licensure form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. If you were licensed in a state that uses the Nursys verification system, you can register with Nursys by calling toll-free (866) 819-1700 or register on-line at www.nursys.com.

5. Foreign educated nurses who have been licensed with no sanctions for at least 5 years in another state, on the basis of SBTPE or NCLEX examinations, must request their nursing school to forward a completed Credentials Form (attached) and transcripts directly to this office. All transcripts must be in English or accompanied by an official English translation. All transcripts must be received directly from the nursing school.

6. Canadian educated nurses not meeting requirement #5 above do not have to be certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS). You must be currently licensed in another state in order to apply by endorsement. In addition to providing the information in #2 and #3 above, you must also arrange for verification of your Canadian license to be sent to this office. You must also contact your nursing school to request that a copy of your final transcripts be sent directly to this office.

7. Foreign educated nurses (other than Canadian) not meeting requirement #5 above must be certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS), 3600 Market Street, Philadelphia, PA 19104-2651, web site www.cgfns.org. Verification of CGFNS certification must be received in this office directly from CGFNS.

PRACTICAL NURSE LICENSURE BY ENDORSEMENT INSTRUCTIONS

1. Complete the application for licensure in its entirety and submit it with the required fee. Applications submitted without the licensing fee will be returned.

2. You must complete **PART I** of the enclosed Practical Nurse Endorsement form and mail it to the state in which you were originally licensed by examination for completion of **PART II** by that state. **Contact your original state of licensure for information regarding fees charged for this service.**

3. In addition to the Endorsement form from your original state of licensure, a Verification of Licensure form must be forwarded to this office **from** EACH additional state in which you hold or have ever held a nursing license. The Verification of Licensure form may be duplicated (You may wish to check with the other state(s) as a fee is usually charged for this service.)

4. If you were licensed in a state that uses the Nursys verification system, you can register with Nursys by calling toll-free (866) 819-1700 or register on-line at www.nursys.com.

5. Foreign nurse graduates must have the school submit a Credentials Form and transcripts to the Michigan Board of Nursing. All credentials must be in English or accompanied by an official English translation. All transcripts must be received directly from the nursing school.

SINCE ALL NURSING LICENSES EXPIRE ON MARCH 31, ORIGINAL LICENSES ARE VALID TO THE FIRST MARCH 31 WHICH MAY BE A YEAR OR LESS; SUBSEQUENT RENEWALS ARE VALID FOR A TWO-YEAR PERIOD.

DCH/LNR-041 (03/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR LICENSURE BY ENDORSEMENT

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING (Check One Only):

- ☐ **Application by Registered Nurse Endorsement Fee: $48.00 71-4704-956**
- ☐ **Application by Practical Nurse Endorsement Fee: $48.00 71-4703-956**

Board Use Only
License Number
Date of Licensure

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	MI License Number and Expiration Date, If applicable

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (If Applicable)

Have you ever held a health professional license in Michigan?

☐ Yes ☐ No

School of Nursing	City and State	Date of Completion

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?**	☐ **Yes**	☐ **No**
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?**	☐ **Yes**	☐ **No**
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ **Yes**	☐ **No**
4. **Have you been treated for substance abuse in the past 2 years?**	☐ **Yes**	☐ **No**
5. **Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?**	☐ **Yes**	☐ **No**
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ **Yes**	☐ **No**
7. **Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?**	☐ **Yes**	☐ **No**

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ❒ Yes ❒ No

9. Have you previously made application to the Michigan Board of Nursing? ❒ Yes ❒ No

10. On what examination basis did you obtain licensure? **SBTPE/NCLEX:** ❒ Yes ❒ No

STATE CONSTRUCTED: ❒ Yes ❒ No

11. Do you hold or have you ever held a nursing license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained. (either endorsement or examination). **You must have each state board verify licensure directly to this board office.** (Attach additional sheets if necessary.) ❒ Yes ❒ No

State	Permanent License Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature	Date

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

REGISTERED NURSE ENDORSEMENT

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

PART I: To be completed by applicant and forwarded to state of original licensure for completion of Part II.

Type or Print Only

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	License Number in Original State
Street Address		
City	State	Zip Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
School of Nursing / City / State		Date of Completion
In which states have you written the licensing examination?		
Signature		Date

PART II: To be completed by the state of original licensure in nursing.

1. This is to certify that the person identified above was granted a registration/license in the State of _____ by:

   ☐ NCLEX ☐ SBTPE ☐ Waiver ☐ Endorsement ☐ Other (indicate method) _____

2. Original License Number _____ Date Issued _____

3. License Status: ❒ Current ❒ Lapsed ❒ Inactive **Expiration Date:** _____

4. Has license been surrendered, suspended, or revoked? If yes, please attach certified copies of any action. ❒ Yes ❒ No

5. Is any disciplinary action pending? If yes, please explain on reverse side. ❒ Yes ❒ No

6. Has license been reinstated? ❒ Yes ❒ No

Name

7. SBTPE Information:

	Score
Medical Nursing	
Psychiatric Nursing	
Obstetrical Nursing	
Surgical Nursing	
Pediatric Nursing	
Series Number	
Date of Examination	

8. NCLEX Information

	Score
Exam Date	
Exam Series	
Exam Score	

9. Was the licensee's nursing educational program approved by your Board when the licensee completed the program? ❒ YES ❒ NO

10. The educational program included theory and practice in:

❒ Medical Nursing ❒ Surgical Nursing ❒ Obstetrical Nursing ❒ Pediatric Nursing ❒ Psychiatric Nursing

Signature	Title	Date

(S E A L)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

PRACTICAL NURSE ENDORSEMENT

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

PART I: To be completed by applicant and forwarded to state of original licensure for completion of Part II.

Type or Print Only

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	License Number in Original State
Street Address		
City	State	Zip Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
School of Nursing / City / State		Date of Completion
In which states have you written the licensing examination?		
Signature		Date

PART II: To be completed by the state of original licensure in nursing.

1. This is to certify that the person identified above was granted a registration/license in the State of _____ by:

   ☐ NCLEX ☐ SBTPE ☐ Waiver ☐ Endorsement ☐ Other (indicate method)_____

2. Original License Number _____ Date Issued_____

3. License Status: ❒ Current ❒ Lapsed ❒ Inactive **Expiration Date:** _____

4. Has license been surrendered, suspended, or revoked? If yes, please attach certified copies of any action. ❒ Yes ❒ No

5. Is any disciplinary action pending? If yes, please explain on reverse side. ❒ Yes ❒ No

6. Has license been reinstated? ❒ Yes ❒ No

Name

7. SBTPE Information:

	Score
Medical Nursing	
Psychiatric Nursing	
Obstetrical Nursing	
Surgical Nursing	
Pediatric Nursing	
Series Number	
Date of Examination	

8. NCLEX Information

	Score
Exam Date	
Exam Series	
Exam Score	

9. Was the licensee's nursing educational program approved by your Board when the licensee completed the program? ❒ YES ❒ NO

10. The educational program included theory and practice in:

❒ Medical Nursing ❒ Surgical Nursing ❒ Obstetrical Nursing ❒ Pediatric Nursing ❒ Psychiatric Nursing

Signature	Title	Date

(S E A L)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

DCH/LNR-030 (03/04)

CREDENTIALS FORM

Authority: Public Act 368 of 1978, as amended.
If this form is not completed for foreign nurse graduates, a license will not be issued

INSTRUCTIONS: This form must be completed by a nursing school for each foreign graduate seeking a license. Please identify areas of classroom instruction and clinical experience from the applicant's program in the subjects listed below. **Please sign and seal the completed form and mail with a copy of the applicant's final transcripts to the address indicated at the top of this form.** This form must be completed in its entirety; incomplete forms will be returned.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Please Check Appropriate Box
		☐ L.P.N. ☐ R.N.

Five Areas of CLASSROOM Instruction:	**Course Titles and Numbers:**
1. MEDICAL	
2. SURGICAL	
3. OBSTETRICS	
4. PEDIATRICS	
5. PSYCHIATRIC	

Five Areas of CLINICAL Instruction:	**Course Titles and Numbers:**
1. MEDICAL	
2. SURGICAL	
3. OBSTETRICS	
4. PEDIATRICS	
5. PSYCHIATRIC	

Was the Nursing Program taught in the English language?	☐ **Yes** ☐ **No**
Name of Educational Institution	

I certify that _____ **attended the**
(Applicant's Name)

educational institution named above from _____ (Month/Day/Year), **to** _____ (Month/Day/Year), **and**

was granted a _____ (level) **degree on** _____ (Graduation Date).

_____
Authorized Signature of Program Representative

_____
Date of Signature

_____
Print or Type Name of Program Representative

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.